



Strategic Business Planning



Strategic Business Planning

Executive Summary Organizational Summary Management Summary Operational Plans Military Readiness

SUBJECT: HEWAUSA RESOLUTION—Quality Health Care

1. Issue: Continue to fund quality health care to ensure continued access for all beneficiaries and to purchase the benefits of war fare.

2. Discussion:

ARMY POSITION: The AMEDD funds quality health care through active involvement in the

SUBJECT: HEWAUSA RESOLUTION—Quality Health Care

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ARMY POSITION: The AMEDD funds quality health care through active involvement in the Defense Health Program (DHP) goals, Objective Memorandum (OCM) process and overall involvement in initiatives offering positive returns. Recent investments in gains are at risk of erosion if you proceed with remains below industry standards.

a. RATIONALE: During FY 2003 the AMEDD made significant and effective investments in the defense system to facilitate system ten efforts at the medical treatment facilities (MTF). The proposed initial funding levels for FY 2004 commensurate this program, not do they allow us to make the additional investments necessary to further increase productivity.

b. TALKING POINTS:

(1) Although OCMHA funded direct care centers and pharmacy at comparable rates above CPI the remaining health care costs are funded at a rate significantly below the industry standard.

(2) The 2004-2009 PCM reduction was documented in anticipation of the expansion of the current fiscal concept's New Medicare Eligible beneficiary rate to funding in fiscal year 2004.

(3) The AMEDD continues and invests in initiatives yielding positive returns on investment through the Veterans Capital Program. In addition, the AMEDD aggressively participates in the Army's Productivity Enhancement Program (PEP) and Business Initiative Council (ABC).

c. BACKGROUND:

(1) The Army's proposed growth for in-house care is limited to 1.5% for FY03. This is a significant under funding when compared to the 2002 PERHP growth of 11.75%. The 2003 National MEDC cost increase of 1.7%, the Military Health Center's estimated growth projection of over 10%, and the role health cost increases anticipated to actual management support contract in all in house.

(2) The Office of Management and Budget (OMB) and the Department of Defense agreed the current funding concept to all Department of Defense in-house, in-house family member and overseas, in purchase of Medicare rates, by giving in fiscal year 2004. The current fiscal year 2004-2009 PCM reduction was documented to reflect the migration of funds from the Defense Health Program to the current fiscal. While the Department has not been able to make in the PCM and performance reduction process, there is potential for the Congress to reject the



Strategic Planning Template

I. Executive Summary

Vision

Mission

Goals & Objectives

Aligned w/ MHS & Service-Specific Goals

Tracked and Reported via Balanced Scorecard

Highlights & Accomplishments

JCAHO Accreditation

Awards/Distinctions/Certificates

Special Designations (i.e., Centers of Excellence, etc.)

Strategic Priorities/Initiatives

Future Product/Service Line Initiatives

Demonstration Projects



Strategic Planning Template

II. Organizational Summary

Governance Structure/Chain of Command

Organizational Structure

Executive Management (Biographies)

Managerial Oversight (Committee

Structures/Reporting Requirements, etc.)

Scope of Services

Inpatient/Ambulatory/Ancillary

Partnerships/Alliances

MCSC/Network Providers

Contracted Arrangements

Resource Sharing, Local Support, Personal Services, etc

VA Sharing Agreements

DoD Referral Facilities



Strategic Planning Template

III. Management Summary

Workload Summary (Prior Two Fiscal Years)

Horizontal & Vertical Analysis

Direct Care

Ambulatory (by primary, specialty, ancillary care)

Inpatient (by specialty)

Resource Sharing

Purchased Care

Ambulatory (by specialty, ancillary care)

Inpatient (by specialty)

Funding Summary (Prior Two Fiscal Years)

O & M Funding

Horizontal & Vertical Analysis

Reimbursements (Third Party Collections/OHI)

Capital Improvements

Equipment (Expense and Investment)

Facility (Modifications, Renovations, etc)



Strategic Planning Template

IV. Operational Plans

A. Market Planning/Analysis

1. Market Size and Demographics

- Geographical Service Area

- Competitor Profiles

- Beneficiary Demographics (by Gender, Age)

 - Enrollment Demographics

 - Prime/Plus, Gender/Age,

 - Zip Code Locations

2. Enrollment Optimization

- Primary Care Optimization (by Age, Gender)

- Specialty Care Optimization (by Age, Gender)

- Ancillary Care Optimization

- Inpatient Optimization

3. SWOT Analysis

- Internal (S-W)/External (T-O)

4. Marketing Objectives

- Enrollment Maximization Strategies

- Beneficiary Satisfaction Strategies

5. Action Plans



Strategic Planning Template

IV. Operational Plans (cont)

B. Financial Planning

1. Demand Forecasting

Changes in Workload (Volume & Expenses)

Changes in Enrollment

Market Share

Changes in Mission

Changes in Scope of Services

Product/Service Lines

Contingencies/Deployment Impact

Staffing Impact

Expense Impact

2. Financial Impact/Analysis

Balance Sheet/Income Statement/Cash Flow

3. Capital Budgeting

Short-Term Requirements (1 year)

Long-Term Requirements (1-3 year)

Break-Even Analysis

Net Present Value

Return on Investment

Funding Prioritizations (listed by FY)



Strategic Planning Temp

V. **Military Readiness**

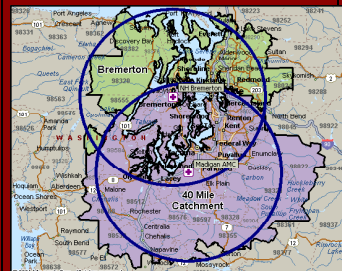
Contingency Planning

Backfill Requirements

Training & Exercise Planning & Expenditures

Strategic Business Planning: Operational Planning – Market Analysis

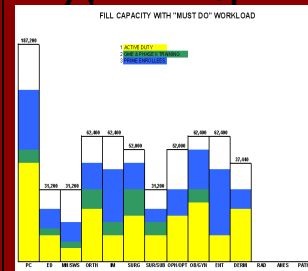
SECTION 1 Market



SECTION 2 Determine Capacity

3000X ARMY COMMUNITY HOSPITAL									
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SECTION 3 Deliberately Fill Capacity



SECTION 4

Identify Capacity Excess/Shortage

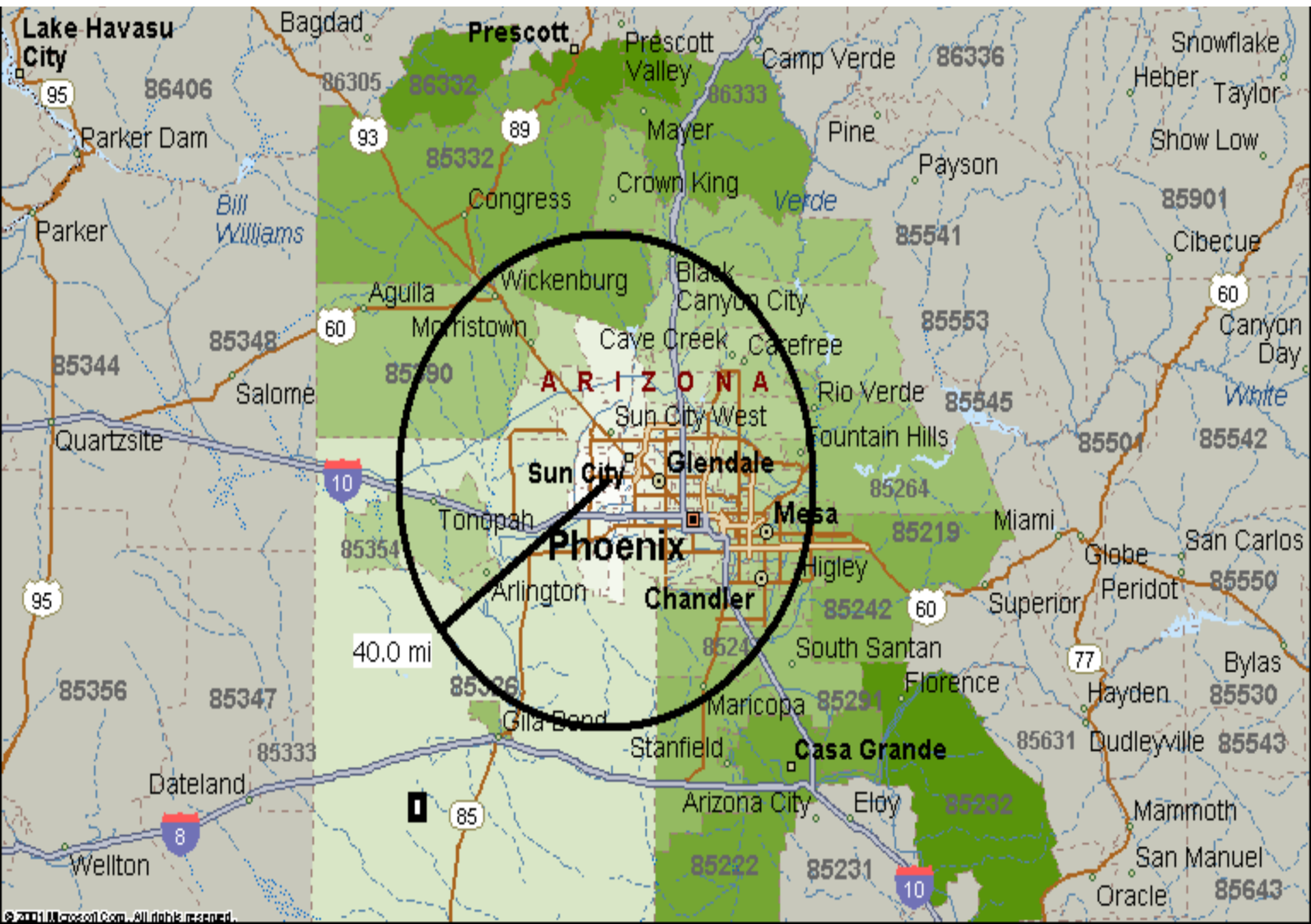
Excess/Shortage

SECTION 5 Determine Funding Requirements

SECTION 6 Determine Manpower

OVERALL SUMMARY - STATEMENT OF REQUIREMENTS		2000 FISCAL YEAR	
1	1	1	1
2	2	2	2
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59	5		

Luke AFB 40 Mile Radius





Market

Analysis

Map of Catchment/Non-Catchment Area

Identify Eligibles & Enrolled by Gender/Age

Determine Market

Segmentation/Penetration %

Identify major routes of egress to facility

Identify Purchased Care Users

Identify VA Service Capabilities

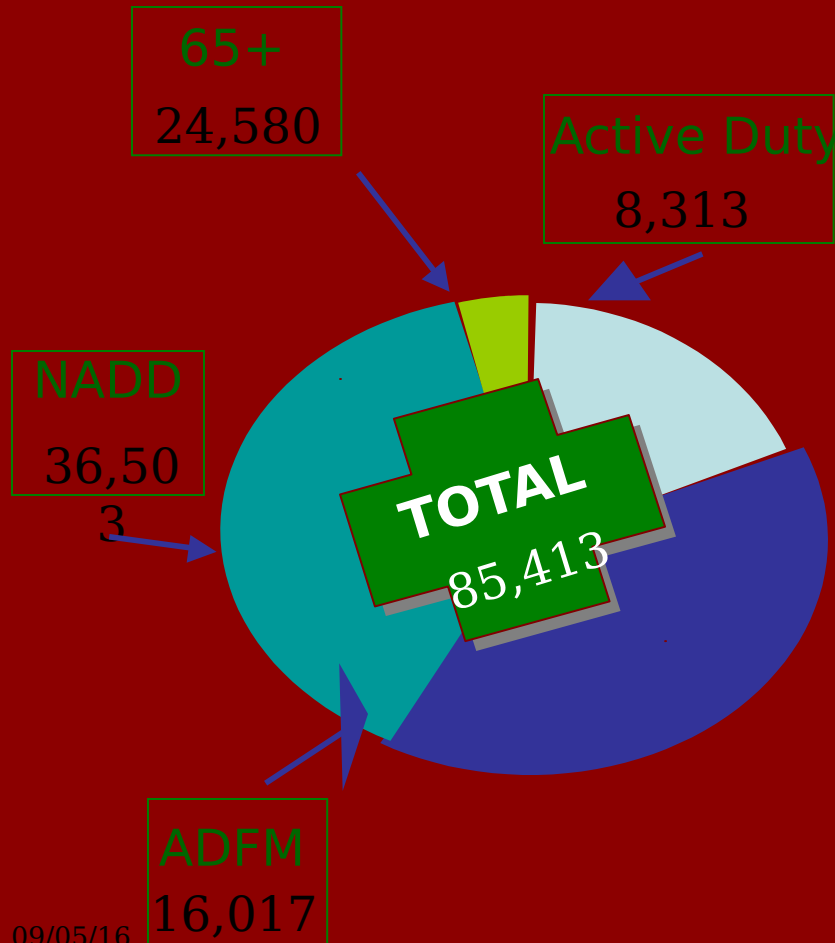
Identify Local Civilian Health Service
Capabilities

Identify MTF Referral Sites

Determine Potential Market Penetration
Opportunities

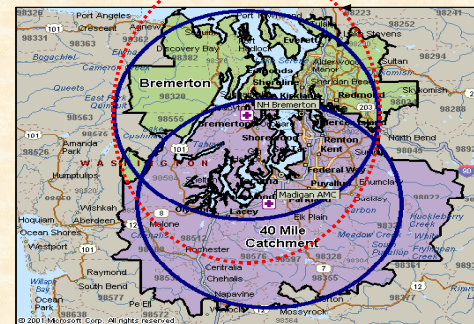
Market Analysis

Eligible Beneficiaries



09/05/16

"Catchment Area"



Total Workload
Catchment Area

Inpatient:
Outpatient:

Outside Catchment
Inpatient:
Outpatient:

Total Workload
Inpatient:
Outpatient:

Purchased Care Referrals

Inpatient:

Outpatient:

VA Referrals

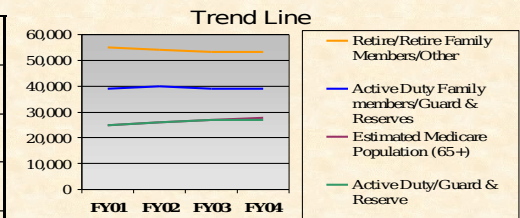
Inpatient:

Outpatient:

12

Catchment Area

Ben Cat	Eligibles	Enrolled	Users
AD	8,313	7,219	
ADFM	16,017	13,766	
Ret/RFM	36,503	18,308	
65+	24,580	919	
Total	85,413	40,211	



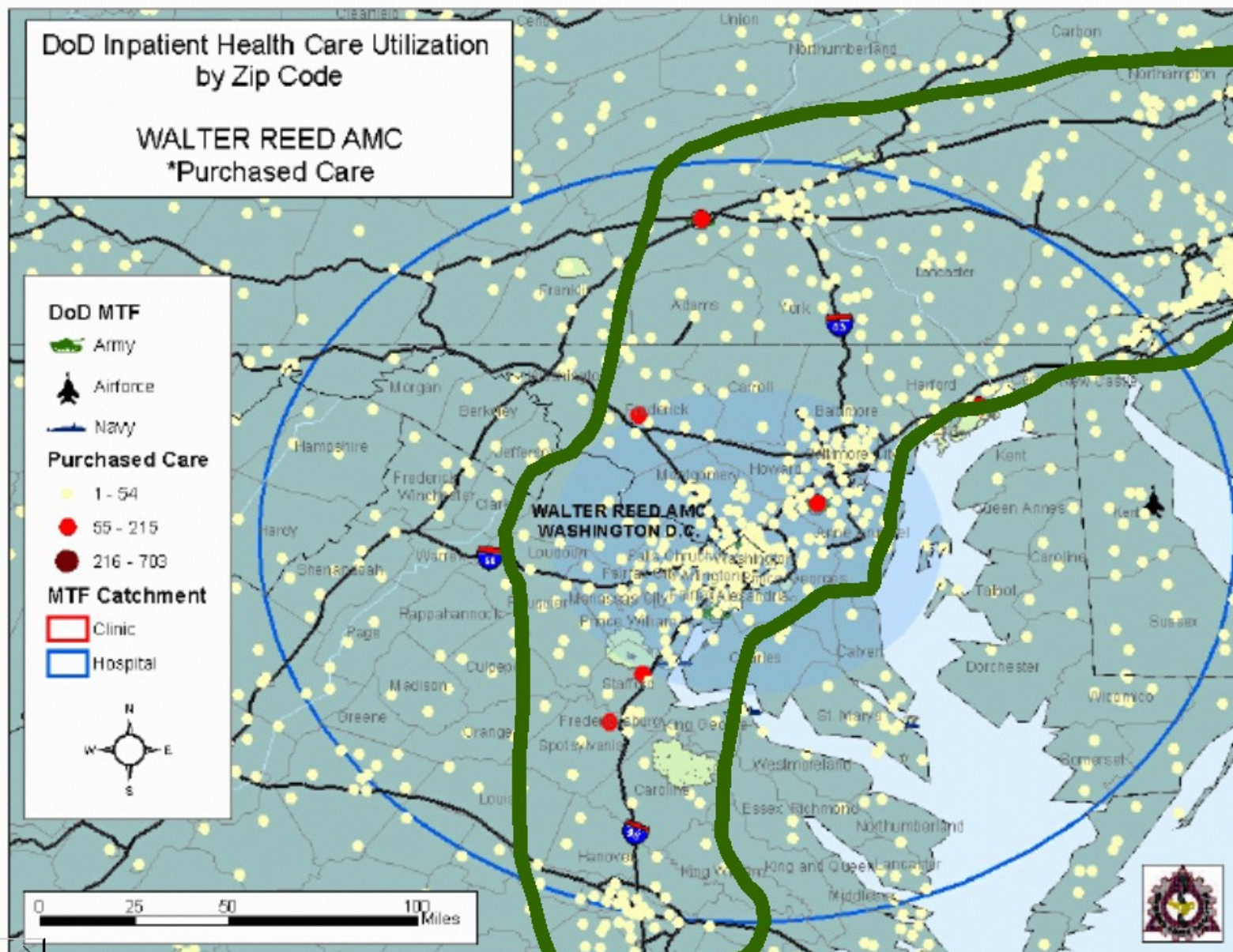
"Flat" population trend line

76% of Eligibles reliant on the MHS...includes McChord, MCSC, etc.

13



Know Your Beneficiaries



Section 2: Determine

XXXXX ARMY COMMUNITY HOSPITAL

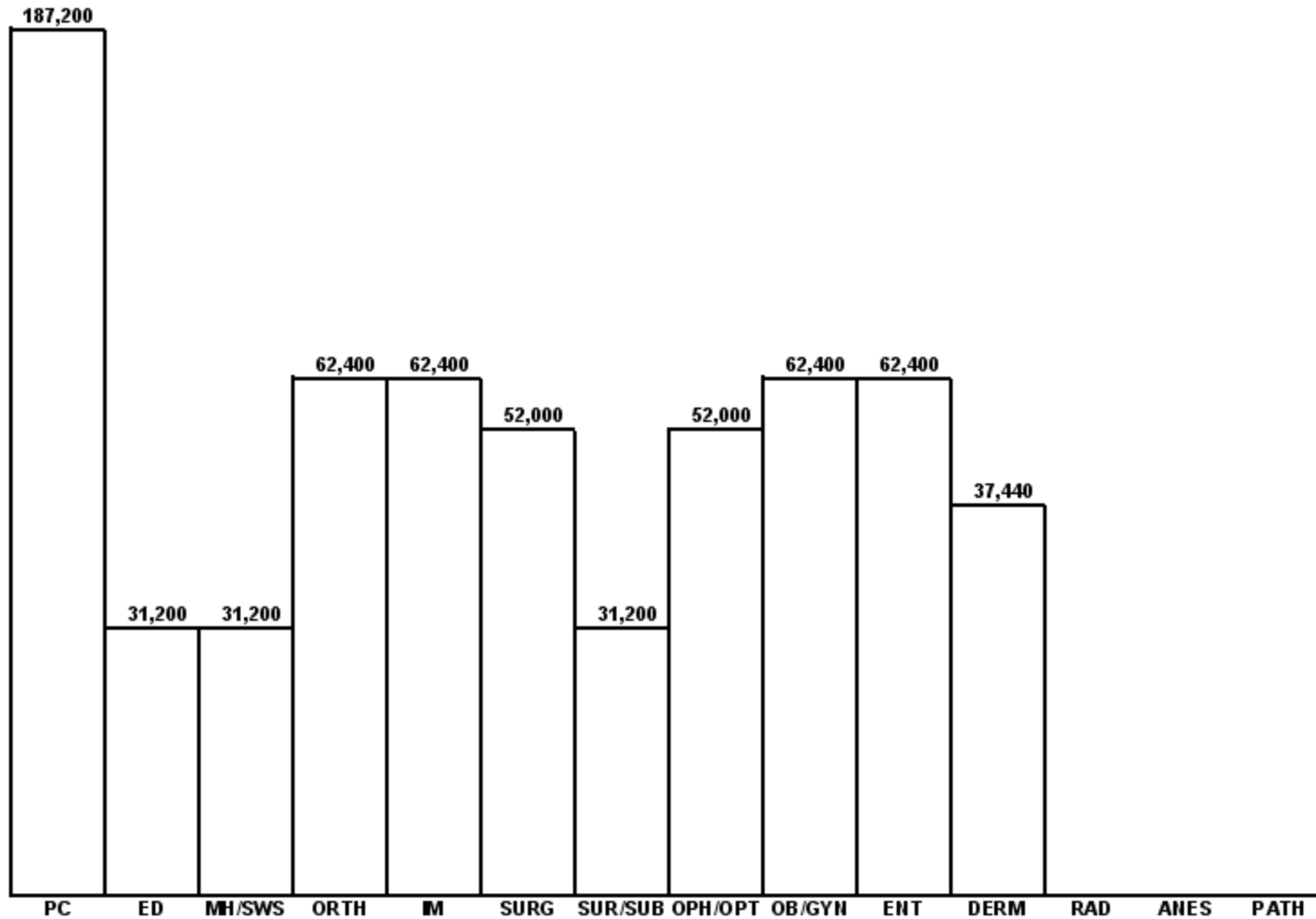
ED	IM	SURGERY	SURG SUB SPECIAL	OB WARD	GYN WARD
2080 Hours per Year 3 RVU's per Hour/Room 30 Rooms PRIMARY CARE			OB/GYN	ANE STH	NEWBORN
			OPHTHAL/OPT	Operating Rooms	ORTHOWARD
			DERM	PATHOLOGY	DIGESTIVE WARD
					CIRCULATIVE WARD
ORTHOPHYS TH	ENT	RADIOLOGY	MH/SWS	MH/SUBSTANCE	NERVOUS WARD
					ENT WARD

CLINIC	NUMBER OF EXAM ROOMS	NUMBER OF TREATMENT ROOMS	RVUs PRODUCED PER EXAM ROOM	RVUs PRODUCED PER TMT ROOM	OUTPATIENT CAPACITY (In RVUs)
Primary Care	26	4	6,240	6,240	187,200
Emergency	13	2	2,080	2,080	31,200
MH/Social Work	4	1	6,240	6,240	31,200
Ortho/Phys Ther	13	7	3,120	3,120	62,400
Internal Med Sub	13	7	3,120	3,120	62,400
Surgery	7	3	5,200	5,200	52,000
Surgery Sub	7	3	3,120	3,120	31,200
Ophth/Opt	7	3	5,200	5,200	52,000
OB/GYN	7	3	6,240	6,240	62,400
ENT	7	3	6,240	6,240	62,400
Dermatology	4	2	6,240	6,240	37,440
Facility				-	-
Radiology				-	-
Anesthesiology				-	-
Pathology				-	-

WARD	NUMBER OF BEDS	RWPs PRODUCED PER BED	INPATIENT CAPACITY (In RVUs)
OB	5	45	225
GYN	5	30	150
Newborn	6	20	120
Respiratory	5	45	225
Ortho	8	60	480
MH	4	30	120
Digestive	6	40	240
Circulatory	8	45	360
Nervous	7	45	315
ENT	4	20	80

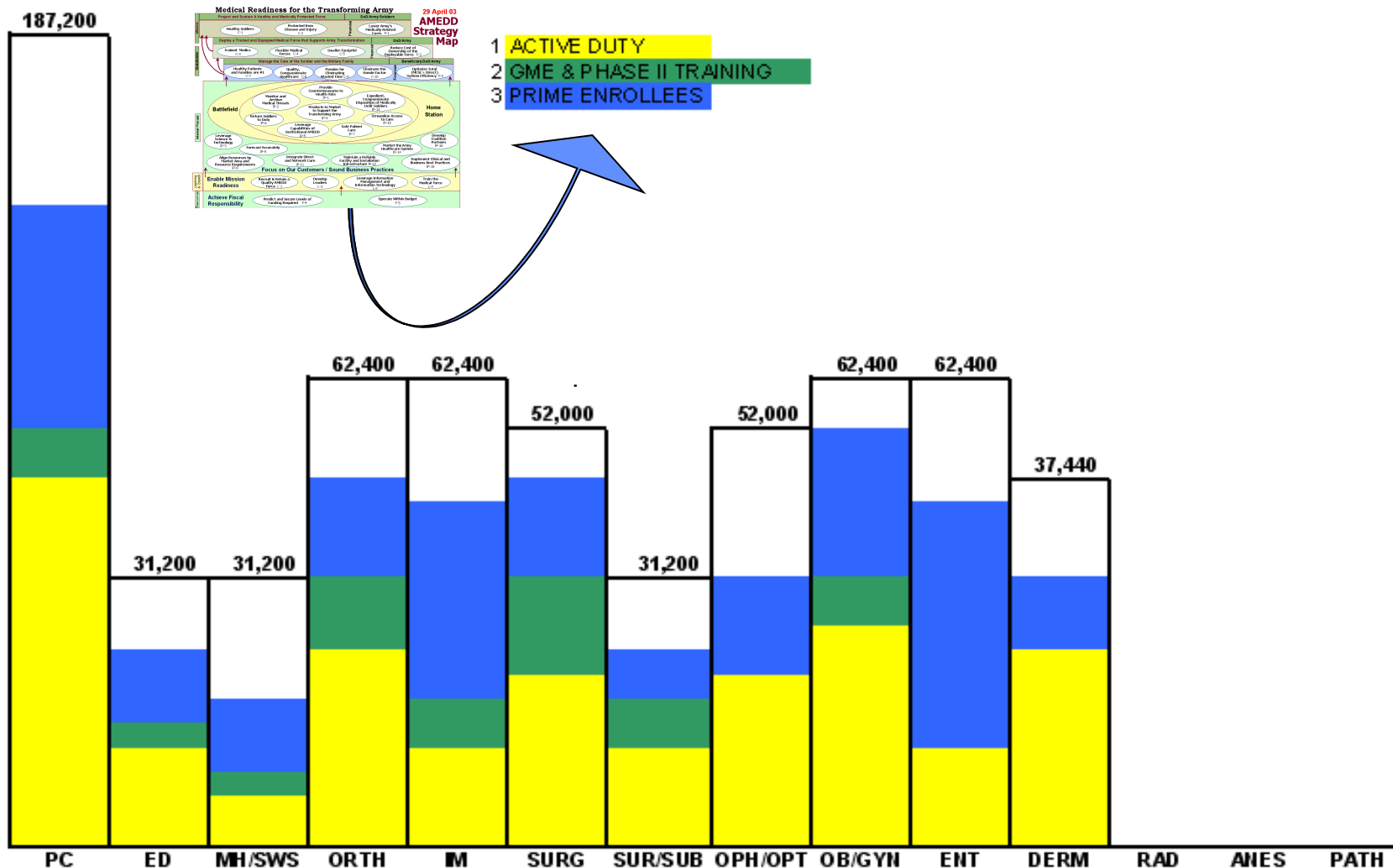
Convert Physical Capacity to Workload Capacity

DETERMINE AVAILABLE CAPACITY



SECTION 3: Deliberately

FILL CAPACITY WITH "MUST DO" WORKLOAD

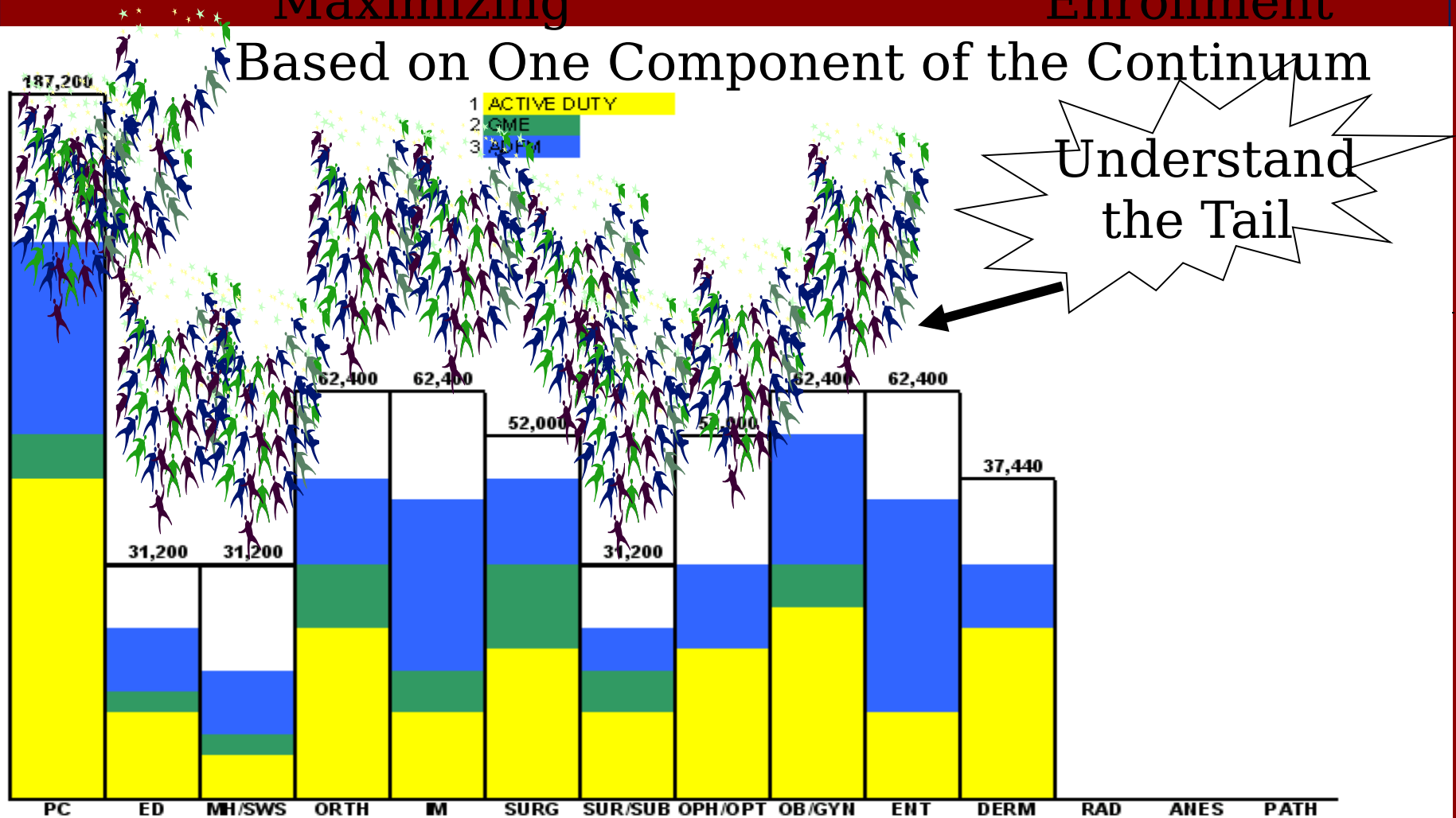


DETERMINE REMAINING ENROLLMENT CAPACITY

CLINIC / WARD	CAPACITY	CONSUMPTION IN RVU'S / RWPS			AVAILABLE	RVU/RWP PERYR	EQUIVALENT ENROLLMENT
		ACT DUTY	GME	ADFM			
Primary Care	187,200	28,080	9,360	37,440	112,320	2.76	40,696
Emergency	31,200	4,680	1,560	6,240	18,720	0.47	39,830
MH/Social Work	31,200	4,680	1,560	6,240	18,720	1.19	15,739
Ortho/Phys Ther	62,400	9,360	3,120	12,480	37,440	0.91	41,168
Internal Med Sub	62,400	9,360	3,120	12,480	37,440	0.90	41,600
Surgery	52,000	7,800	2,600	10,400	31,200	0.70	44,571
Surgery Sub	31,200	4,680	1,560	6,240	18,720	0.80	23,400
Ophth/Opt	52,000	7,800	-	10,400	33,800	0.50	67,882
OB/GYN	62,400	9,360	3,120	12,480	37,440	0.69	54,527
ENT	62,400	9,360	-	12,480	40,560	0.60	67,600
Dermatology	37,440	5,616	-	7,488	24,336	0.40	60,840
Facility		-	-	-	-		
Radiology		-	-	-	-		
Anesthesiology		-	-	-	-		
Pathology		-	-	-	-		
OB Ward	225	34	11	45	135	0.0021	64,286
GYN Ward	150	23	8	30	90	0.0013	69,231
Newborn Ward	120	18	6	24	72	0.001	72,000
Respiratory Ward	225	34	11	45	135	0.006	22,500
Ortho Ward	480	72	24	96	288	0.008	36,000
MH/Substance Wk	120	18	6	24	72	0.0008	90,000
Digestive Ward	240	36	12	48	144	0.005	28,800
Circulatory Ward	360	54	18	72	216	0.009	24,000
Nervous Ward	315	47	16	63	189	0.008	23,625
ENT Ward	80	12	4	16	48	0.0006	80,000

Second Order Effects of Enrollment

Maximizing
Based on One Component of the Continuum



Section 4: Identify

Areas of Capacity Excess/Shortage

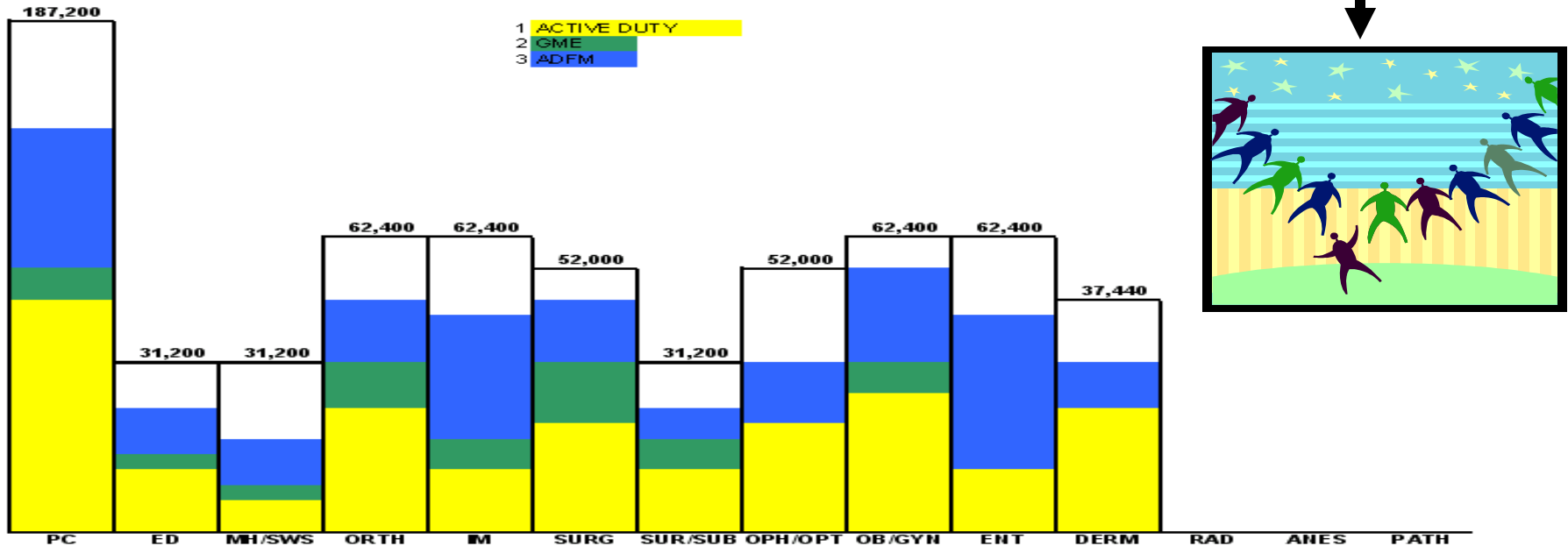
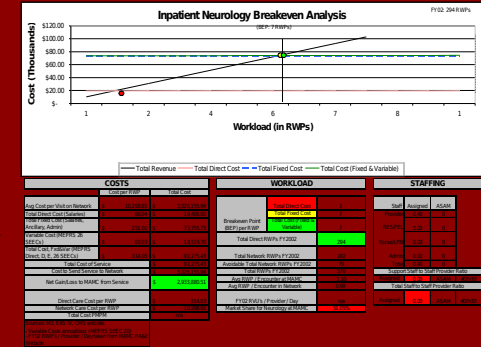
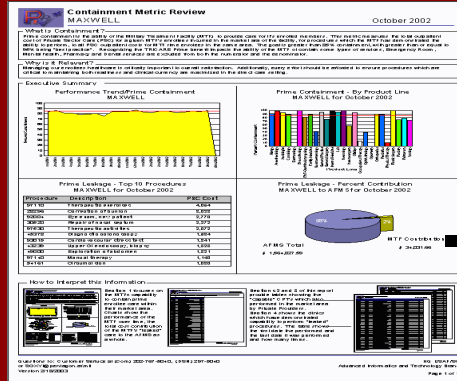
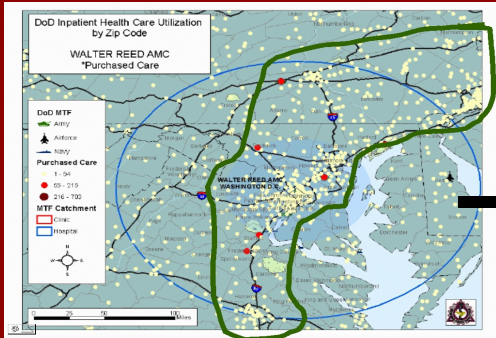
Second Order Effects of Maximizing Enrollment Based on One Component of the Continuum

CLINIC / WARD	EQUILMANT ENROLLMENT	IMPACT OF 100 % PC ENROLLMENT	CAPACITY (RVU/RWP) EXCESS / SHORTAGE
Primary Care	40,696	-	-
Emergency	39,830	(866)	(407)
MH/Social Work	15,739	(24,957)	(29,684)
Ortho/Phys Ther	41,168	473	430
Internal Med Sub	41,600	904	814
Surgery	44,571	3,876	2,713
Surgery Sub	23,400	(17,296)	(13,837)
Opt/Opt	67,882	27,187	13,537
OB/GYN	54,527	13,831	9,497
ENT	67,600	26,904	16,143
Dermatology	60,840	20,144	8,058
Facility			
Radiology			
Anesthesiology			
Pathology			
OB Ward	64,286	23,590	50
GYN Ward	69,231	28,535	37
Newborn Ward	72,000	31,304	31
Respiratory Ward	22,500	(18,196)	(109)
Ortho Ward	36,000	(4,696)	(36)
MH/Substance Ward	90,000	49,304	39
Digestive Ward	28,800	(11,896)	(59)
Circulatory Ward	24,000	(16,696)	(150)
Neurology Ward	23,625	(17,071)	(137)
ENT Ward	80,000	39,304	24

RWP's/RVUs
For Sale
or Required
from Others

Section 5: Funding Requirements

Make vs. Buy Analysis



Who Is Treating Them When You Are Not



Containment Metric Review MAXWELL

October 2002

What is Containment?

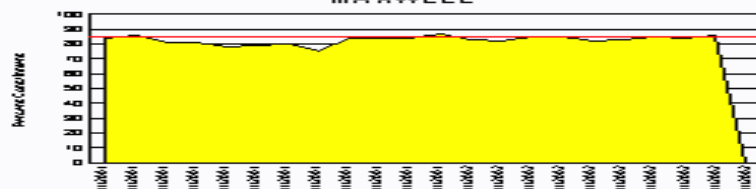
Prime containment is the ability of the Military Treatment Facility (MTF) to provide care for its enrolled members. This metric measures the total outpatient cost or Private Sector Care (PSC) for a given MTF's enrollees incurred in the market area of the facility, for procedures which the MTF has demonstrated the ability to perform, to all PSC outpatient costs for MTF prime enrollees in the same area. The goal is greater than 85% containment, with greater than or equal to 95% being "best practice". Recognizing the TRICARE Prime benefit impacts the ability of the MTF to contain some types of services, Emergency Room, Mental Health, Pharmacy and Dental services are excluded from both the numerator and the denominator.

Why is it Relevant?

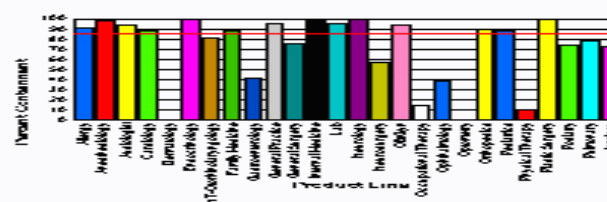
Managing our enrollees' healthcare is critically important to our retail satisfaction. Additionally, every effort should be afforded to ensure procedures which are critical to maintaining both readiness and clinical currency are maximized in the direct care setting.

Executive Summary

Performance Trend/Prime Containment MAXWELL



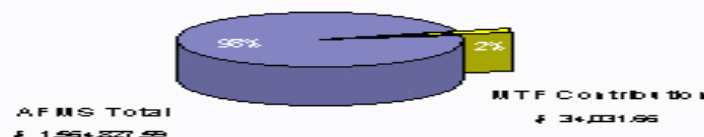
Prime Containment - By Product Line MAXWELL for October 2002



Prime Leakage - Top 10 Procedures MAXWELL for October 2002

Procedure	Description	PSC Cost
57110	Therapeutic exercise	4,064
26296	Correction of union	3,022
52004	Eye exam, new patient	2,776
30520	Repair of nasal septum	2,232
57530	Therapeutic services	2,072
45375	Diagnostic colonoscopy	1,854
53015	Cardiovascular direct test	1,241
43239	Upper GI endoscopy, biopsy	1,225
45000	Exploration of abdomen	1,221
57140	Manual therapy	1,140
54161	Circumcision	1,020

Prime Leakage - Percent Contribution MAXWELL to AFMS for October 2002



How to Interpret this Information



Section 1 focuses on the MTF's capability to contain prime enrollee care within the market area. Charts show the performance of the MTF over time, the total cost contribution of the MTF's "leaked" care to the AFMS as a whole.



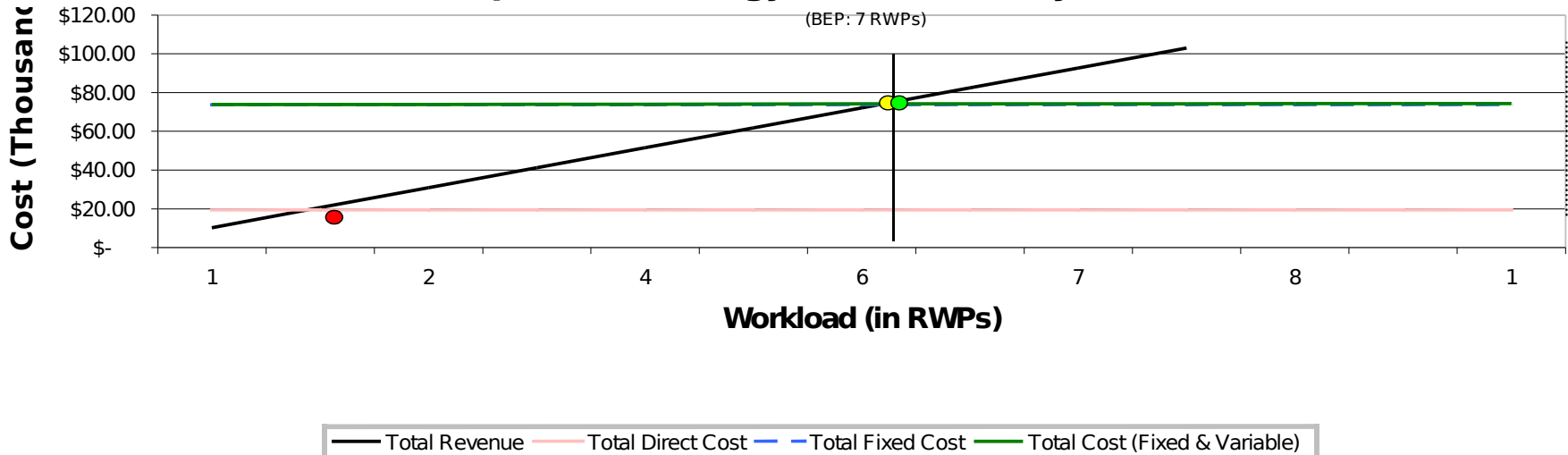
Section 2 and 3 of this report provide tables showing the "capable" CPTs which also performed in the market area by Private Providers. Section 4 shows the clinics which have demonstrated capability to perform "leaked" procedures. The table shows the first date the procedure was performed and the last date it was performed and how many times.



Should You Be Treating Them ?

Inpatient Neurology Breakeven Analysis

FY02: 294 RWPs



COSTS		
	Cost per RWP	Total Cost
Avg Cost per Visit on Network	\$ 10,298.65	\$ 3,026,155.94
Total Direct Cost (Salaries)	\$ 66.04	\$ 19,406.00
Total Fixed Cost (Salaries, Ancillary, Admin)	\$ 251.01	\$ 73,755.73
Variable Cost (MEPRS 26 SEECs)	\$ 63.03	\$ 18,519.70
Total Cost, Fxd&Var (MEPRS Direct, D, E, 26 SEECs)	\$ 314.03	\$ 92,275.43
Total Cost of Service		\$ 92,275.43
Cost to Send Service to Network		\$ 3,026,155.94
Net Gain/Loss to MAMC from Service		\$ 2,933,880.51
Direct Care Cost per RWP		\$ 314.03
Network Care Cost per RWP		\$ 10,298.65
Total Cost PMPM		n/a

Sources: M2, EAS IV, CMS website.

- Variable Costs annualized. (MEPRS SEEC 26)

- FY02 RWP's / Provider / Day taken from MAMC PA&E Website

WORKLOAD		
	Total Direct Cost	2
	Total Fixed Cost	7
Breakeven Point (BEP) per RWP	Total Cost (Fixed & Variable)	7
Total Direct RWPs FY2002		294
Total Network RWPs FY2002		282
Avoidable Total Network RWPs FY2002		79
Total RWPs FY2002		576
Avg RWP / Encounter at MAMC		1.10
Avg RWP / Encounter in Network		0.99
FY02 RVU's / Provider / Day		n/a
Market Share for Neurology at MAMC		51.05%

STAFFING			
Staff	Assigned	ASAM	
Provider	0.40	0	
RES/FEL	0.00	0	
Nurse/LPN	0.00	0	
Admin	0.00	0	
Total	0.40	0	
Support Staff to Staff Provider Ratio			
Assigned	0.00	ASAM	#DIV/0!
Total Staff to Staff Provider Ratio			
Assigned	0.00	ASAM	#DIV/0!



Primer

Primary Care Population Formula

$$A + B + C \times 2.5 + D + E + F \times 2.5 + G$$

A =	B =	C =	D =	E =	F =	G =
TRICARE Prime Enrolled Age 0-17	TRICARE Prime Enrolled Age 18-64	TRICARE Prime Enrolled Age 65+	Non-Prime Users Age 0-17 3 or more visits	Non-Prime Users Age 18-64 3 or more visits	Non-Prime Users Age 65+ 3 or more visits	AD Trainees
SOURCE: DEERS (M2)	SOURCE: DEERS (M2)	SOURCE: DEERS (M2)	SOURCE: SADR	SOURCE: SADR	SOURCE: SADR	SOURCE: TRADOC (DCSRM)

A, B, & C include projected adjustments in the enrolled population for the effective date of the TDA.

POPULATION DATA SOURCES

DEERS (Defense Eligibility Enrollment System)
SADR (Standard Ambulatory Data Record)
TRADOC (U.S. Army Training and Doctrine Command)

Patient to Primary Care Provider Ratio

3 visits/hr x 7.5 hrs/day x 20.91 days/mo x 12 months = 5645.7 visits/yr

5645.7 visits/yr divided by 4.136 visits/yr/patient = 1365 patients/provider

BUT this is based on availability of 7.5 hrs/day x 20.91 days/mo = 156.83 hrs/mo

Military providers are available 126.65 hrs/month
(Army standard 145.03 hrs/mo - 3.33 hrs/mo CME - 15.05 hrs/mo readiness)

Thus military providers can see 126.65 hrs/mo x 3 visits/hr x 12 mo = 4559 visits
which equates to 4559 visits divided by 4.1 visits/patient = 1112 patients/provider

Government civilian providers are available 141.7 hrs/month
(Army standard 145.03 hrs/mo - 3.33 hrs/mo CME)

Thus govt civilian providers can see 141.7 hrs/mo x 3 visits/hr x 12 mo = 5101 visits
which equates to 5101 visits divided by 4.1 visits/patient = 1244 patients/provider

Therefore the average number of patients per primary care provider is 1178
(1112 + 1244 = 2356/2 = 1178)

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Specialty Care Population Formula

$$A + B + C \times 2.5 + D + E + F \times 2.5 + G + H + I + J \times 2.5$$

A =	B =	C =	D =	E =	F =	G =	H =	I =	J =
TRICARE Prime Enrolled Age 0-17	TRICARE Prime Enrolled Age 18-64	TRICARE Prime Enrolled Age 65+	Non-Prime Users Age 0-17 3 or more visits	Non-Prime Users Age 18-64 3 or more visits	Non-Prime Users Age 65+ 3 or more visits	AD Trainees	Enrolled Elsewhere Users Age 0-17 3 or more visits	Enrolled Elsewhere Users Age 18-64 3 or more visits	Enrolled Elsewhere Users Age 65+ 3 or more visits
SOURCE: DEERS (M2)	SOURCE: DEERS (M2)	SOURCE: DEERS (M2)	SOURCE: SADR	SOURCE: SADR	SOURCE: SADR	SOURCE: TRADOC (DCSRM)	SOURCE: SADR	SOURCE: SADR	SOURCE: SADR

A, B, & C include projected adjustments in the enrolled population for the effective date of the TDA.

POPULATION DATA SOURCES

DEERS (Defense Eligibility Enrollment System)
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Support Staff to Primary Care Provider Ratio

MHS Primary Care Optimization Plan recommends 3 support staff to each primary care provider

A recent study by MEDCOM PAE concluded that high performing MEDCOM MTFs averaged 2.7 to 2.8 support staff per primary care provider

MGMA literature reports better performing managed care operations employ 2.8 support staff to primary care provider

Therefore we decided to use a 2.8 support staff to primary care provider ratio for initial application of ASAM III

The recommended distribution of the 2.8 support staff is .5 Registered Nurse, 1.8 Licensed Practical Nurse/Nurse Assistant, and .5 Medical Clerk

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Patient to Specialty Care Provider Ratios

Patient to specialty care provider ratios were determined after review of MGMA literature and consultation with specialty consultants to The Surgeon General

The following represent a sampling of some of the specialty care providers:

Cardiology 30,000:1
Dermatology 35,000:1
Allergy 60,000:1
Psychiatry 18,000:1
General Surgery 12,500:1
Orthopedic Surgery 14,285:1
Neurosurgery 70,000:1
Ophthalmology 25,000:1
Obstetrics/Gynecology 11,000:1
Radiology 12,000:1

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Staffing Primer

Support Staff to Specialty Care Provider Ratios

Specialty	RN	LPN	NA	Med Clerk	Total Ratio
Multi-specialty Groups	0.4	0.6	0.9	0.4	2.3
Medicine Single Specialty	0.6	0.5	0.9	0.4	2.4
Surgery Single Specialty	0.4	0.6	0.9	0.4	2.3
Cardiology	0.4	0.4	0.6	0.6	2
OB/GYN	0.5	0.9	0.9	0.7	3
Psychiatry	0	0	1	0.2	1.2

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SECTION 7: Action Plans

- Align Objectives with Strategic Goals
 - Objectives should be clearly defined and measurable
- Evaluate Organizational Position with Desired Objectives via SWOT Analysis
- Develop action plans to accomplish objectives
 - Must be Specific and Quantified
 - Must Be Scheduled and Implemented with Specific Time Frames
 - Must be Reviewed Periodically (Quarterly, Semi-Annually)
 - Enrollment Optimization & Beneficiary Satisfaction Strategies
 - Evaluate and redefine/redirect efforts if necessary



SECTION 8: Performance Measurement

- Establish performance targets in the business plan and then monitor performance against the plan (vs. historical trends)
- Links resourcing decisions to business plans and their execution

Questions ?